FINANCIAL ELIGIBILITY (FY 2017)

DHS-DD-700 (05/16)

Instructions	**Community Support Provider Use Only**	
Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by the Division of Developmental Disabilities.	☐ **Eligible –** Annual Review Date:	
	☐ **Ineligible**	
	CID #:	Signature:

Personal Information

(Please Print)

Participant Name: _____
(First) *(MI)* *(Last)*

SSI Eligible? ☐ yes or ☐ no; If **yes**– there is not a need to complete the remainder of this form.

Parent/Guardian or Representative (if applicable): _____

Description of Household

Total Number of Persons Living in Household (include spouse and non-adult children residing in the home): _____

Financial Information

Total Household Annual Gross Income:

1) $_____ unearned
2) $_____ earned
3) $_____ Total

Minus Annual Deductions/Expenses:

4) $_____ Earned Income Deduction (20% of Earned Income **only** – do not include a deduction on any unearned income.)

5) $_____ Childcare ($3,000 per child/year, up to a maximum of $6,000/year)

6) $ _____ Child Support Payments

Annual Disability Related Expenses (*please describe*)

7) $_____ Prescription Medications/Labs _____

8) $_____ Health Insurance Premiums _____

9) $_____ Assistive Devices (e.g., medication reminder) _____

Equals Annual Net Income:

10) $_____ (deduct lines 4 through 9 from line 3)

Household Size	185% Annual Income
1	$21,978
2	$29,637
3	$37,296
4	$44,955
5	$52,614
6	$60,273
7	$67,951
8	$75,647

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify the Community Support Provider so that eligibility can be reevaluated. Eligibility could be affected by increases in income, changes in the number of persons in my household, and/or any other significant change in financial circumstance.

_____ _____

Signature (Consumer or Parent/Guardian) Date

OVER →

EMERGENCY PROVISIONS ONLY

Please answer the following question only if the consumer is in an emergency situation, does NOT meet eligibility criteria, but your agency is requesting to provide CTS under emergency provisions outlined in the contract.

1. Does the participant's income fall below 115 percent of state median income ($44,550 for a family of one through May 31, 2017)?

2. What other service options have been explored and exhausted? (i.e. vocational rehabilitation, mental health services)

3. What risk is presented to the participant if CTS services are not provided?

DDD Use only
☐ Approved on _____ (date) effective _____ (date)
☐ Denied on _____ (date). Reason: